

Iowa OSHA

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FOR OFFICE USE ONLY

Received by: _____
 Sent by: Fax Phone Email
 Date: _____ Time: _____
 Inspection planned: Yes No
 Inspection #: _____ CSHO: _____
 Autopsy performed: Yes No

Incident Report

Enter # of affected employees: Fatality Hospitalization Loss of an eye Amputation

Business name			Federal ID #		NAICS		Total employees			
Mailing address			City			State		Zip		
Phone		Fax		Business activity						
Ownership		Private		Local Government		State Government		Federal Agency		
								Union? Yes No		
Your name				Job title						
Phone number		Fax number		Email address						
Event address		Same as mailing address		City			State		Zip	
Victim's name			Age		Occupation					
Employee type		Current		Temporary		Accident date		Accident time		
Description of incident										

Fatality next of kin information

Name		Relationship		Phone number	
Mailing address		City		State Zip	